HEADQUARTERS
UNITED STATES EUROPEAN COMMAND
UNIT 30400
APO AE 09131-4209

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HEALTH SERVICE SUPPORT

USEUCOM Patient Movement System

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1. Summary. This directive establishes policy, delineates responsibilities, and provides guidance and procedures concerning the United States European Command's patient movement (PM) system, including Service component integration and support requirements, and Theater Patient Movement Requirements Center-Europe (TPMRC-E) interface. The May 1997 Memorandum of Understanding between USEUCOM/ECMD and USAFE/SG, as amended by USAFE/CC message (DTG 171609Z NOV 98), subject; "TRANSFER OF USEUCOM THEATER PATIENT MOVEMENT REQUIREMENTS CENTER (TPMRC) TO COMUSAFE," is hereby superceded.

2. Applicability. The provisions of USEUCOM Directive (ED) 67-2 apply to all agencies involved in the coordination or actual movement of patients through the USEUCOM PM system and/or the military health services system. USEUCOM service component compliance with this directive is mandatory.

3. Internal Controls System. This document is not subject to internal management controls as outlined in ED 50-8, Internal Management Control Program.

4. Suggested Improvements. Recommended changes or improvements should be forwarded directly to Commander, TPMRC-E, Unit 7590, APO, AE 09094-7590 or emailed to tpmrceurope@ramstein.af.mil. Changes to this directive will be coordinated with USEUCOM, service components and the TRICARE Europe Office.

5. References.

a. Joint Pub 1, Dictionary of United States Military Terms for Joint Usage

b. Joint Pub 4-02.2, JTTP for Patient Movement in Joint Operations

c. Joint Federal Travel Regulation Vol 1 and Vol 2

d. DoD Instruction 6000.11, Patient Movement

This Directive Supersedes ED 67-2, dated 15 October 1998.

e. DoD Directive 6000.12, Change 1, Health Services Operations and Readiness

f. DoD Program Budget Decision 710, *Defense Reform Initiative - Joint Programs,* 17 Dec 97

g. AFI 41-115, Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)

h. AFI 41-302, Aeromedical Evacuation Operations and Management

i. AFI 41-306, Physicians Roles & Responsibilities in Aeromedical Evacuation

j. AFH 41-114, Military Health Services System Matrix

k. AFTTP 3-42.5, Aeromedical Evacuation

l. AR 40-20, Evacuation of Patients

m. Medical Regulating To and Within CONUS, AFJI 41-315, AR 40-350, BUMEDINST 6320.1D

n. Medical Support in Joint Operations, FM 8-8, NAVMED P-5047, AFM 160-20

o. Worldwide Aeromedical Evacuation, AFI 41-301, AR 40-535, OPNAVINST 4630.0C, MCO P4630.9A

6. General Patient Movement Concept of Operations. The primary mission of the DoD patient movement system is to transport safely U.S. military casualties from the combat zone to fixed MTFs and/or field hospitals rearward in or out of the combat zone, as required. Other patients may be provided movement on a non-interference basis if the patient's medical condition, lack of local care, and patient movement costs warrant such movement. The main goal of the USEUCOM PM system is to ensure continuity and quality of care by providing patient-focused "door-to-door" service, maintaining the maximum in-transit visibility (ITV) practical, and providing 24-hour/7-days-a-week assistance.

7. Responsibilities. The USEUCOM Commander has primary authority and responsibility for establishing and maintaining a theater patient movement system supporting intra-and inter-theater PM. COMUSAFE is designated as the USEUCOM Commander's executive agent for management of PM matters to, from, and within the USEUCOM area of responsibility (AOR) and interest (AOI) in peacetime and contingency operations. TPMRC-E will retain joint staffing composition as identified in PBD 710 and this directive.

a. USEUCOM will:

(1) Be responsible for intratheater patient movement within the USEUCOM area of responsibility.

(2) Within capability, or as negotiated through specific Command Arrangement Agreements, support all PM requests received from United States Central Command (USCENTCOM) MTFs until a self-sustaining theater PM system is established.

(3) In coordination with TPMRC-E coordinate requests for movement of non-eligible (both U.S. national and foreign national) patients for Joint Force Commander approval.

(4) Coordinate with United States Transportation Command (USTRANSCOM) to support PM movement to, from, and within the USEUCOM AOR/AOI.

b. COMUSAFE will:

(1) Establish and maintain a fully functional TPMRC-E and act on behalf of the USEUCOM Commander as executive agent for purposes of administration, support and coordination of common functions relating to patient movement and regulating matters to, from and within the USEUCOM AOR/AOI.

(2) Establish and provide administrative control (ADCON) for the TPMRC-E as a Major Command Field Operating Agency (FOA) which reports directly to the HQ USAFE Command Surgeon as a MAJCOM division equivalent.

(3) Coordinate with USTRANSCOM and Air Mobility Command (AMC) to support the PM mission to, from and within the USEUCOM AOR/AOI.

(4) Review and investigate processes for AE quality assurance items, issues or concerns. As appropriate, forward information regarding such events to the AMC/USTRANSCOM and USEUCOM Surgeons.

(5) Maintain the Air Mobility Operations Control Center (AMOCC) as the primary agent responsible for command and control (C2) of USAFE AE assets in support of PM, to include coordination of PM support taskings with other strategic, theater, or USAFE C2 agencies.

(6) Maintain an AE Division within the AMOCC to perform AE operational mission coordination and planning/tasking of USAFE AE crews and AE-support assets. The AE Division will support USEUCOM patient movement and function in coordination with the Global Patient Movement Requirements Center (GPMRC), the TPMRC-E, service component installation agencies, USEUCOM Joint Movement Center (JMC), and the AMC TACC/AE Cell. The AMOCC/AE Division will:

(a) Receive validated AE requirements from TPMRC-E, conduct mission planning, track and monitor AE missions, and coordinate required operational support for AE missions.

(b) Generate and coordinate intratheater AE plans and schedules.

(c) Coordinate mission changes if necessitated by patient requirement and/or medical direction prior to and during mission execution.

(7) Execute the PM mission thru the air component's AE system, under the OPCON of the Commander of Air Force Forces (COMAFFOR) through the Air Operations Center (AOC) infrastructure.

(8) Establish a patient movement item (PMI) center to maintain PMI at levels sufficient to support theater requirements. The PMI center will be responsible for the overall management, intransit visibility, maintenance, and tracking of their PMI.

(9) Provide 14 manpower positions to staff TPMRC-E to augment the "cross-departmental" positions identified in PBD 710.

c. Service Component Commanders will:

(1) Ensure medical treatment facilities (MTFs) provide to TPMRC-E information pertaining to medical specialties, patient movement, quality assurance, bed status, and other information upon request.

(2) Support U.S. and NATO operations and exercises requiring simulated or actual PM support as directed by the COMUSEUCOM.

(3) Provide scheduled airlift on an "as available" basis for routine PM (patients who require movement but can wait for a regularly scheduled channel AE mission, a scheduled military airlift channel mission, or commercially-procured airlift). Make available en-route/executing airlift for urgent/priority PM (patients requiring movement immediately/within 24 hours to save life, limb, or eyesight).

(4) Support theater PM by executing validated PM requirements via surface (land or water) or air (rotary-wing, tilt-wing, or fixed-wing aircraft) using dedicated, designated, opportune, or commercial assets.

(5) Ensure assigned MTFs are available to the TPMRC-E for regulation of patients based on medical capability and patient requirement(s).

(6) Fill existing Service-specific manpower authorizations as described in PBD 710 (see Appendix A).

(7) Budget for and fund service-specific training requirements for service staff members assigned to TPMRC-E.

(8) Provide augmentation on order to the TPMRC-E for staff expansion during crisis action/contingency support per Appendix A. Augmentation responsibilities include clinical and administrative validation of patients, manifesting/controlling, and transportation planning/procurement.

(9) Ensure MTFs utilize TRANSCOM's Regulating and Command & Control Evacuation System (TRAC2ES).

(10) Identify funding for alternate PM modes FY06 and beyond.

d. MTFs (aeromedical staging facilities (ASFs) where applicable) will:

(1) Pursue referral opportunities for local care when indicated.

(2) If local care is not appropriate, submit patient movement requests (PMRs) to TPMRC-E utilizing TRAC2ES whenever possible. Ensure patient information is accurate, complete, and complies with applicable regulations and policies.

(3) Perform a referral cost analysis on all PMRs IAW DoD 6000.11 for all patients for whom local accountability is transferred when moved from one facility to another. This includes all patients remaining overnight away from the originating MTF. MTFs will consider the most cost effective source of quality care and mode of transportation. If the patient is capable of traveling via commercial air (i.e., the patient does not require any care in the air and is ambulatory), consider commercial air as an option for the cost analysis and PMR submission.

(4) Ensure that applicable regulations, directives, and policies are properly followed in selection, approval, preparation, cost analysis review, and administrative processing of patients recommended for PM.

(5) Identify facility medical specialty capabilities to the TPMRC-E quarterly unless otherwise directed. When designated as a patient reception MTF during contingencies, provide medical capability reports to the TPMRC-E (or JPMRC if established) daily or as directed.

(6) Provide or arrange for appropriate medical care, personnel, administrative, and well being support. Support should include clothing, billeting, messing, finance, and transportation of patients and attendants who have not yet departed from an originating MTF for a destination MTF, have been regulated to a destination MTF by the TPMRC-E, and/or will remain overnight.

(7) Appoint a flight surgeon or competent medical authority to review requests for commercial airlift submitted by attending physicians. Ensure a statement of compliance (available on the TPMRC-E website) is signed by the sending physician, appointed flight surgeon/competent medical authority, and individual to signify confirmation of compliance with guidelines.

(8) Assist with in-transit visibility by reporting patient travel information to TPMRC-E and appropriate service personnel liaisons. Maintain continuous visibility of patients during inpatient and outpatient treatment in conjunction with service personnel liaisons.

(9) Ensure all persons in the rank of O-6 equivalent or higher who are medically regulated as patients or attendants are afforded all DV protocols and, if desired, such protocols are appropriately coordinated before departure from originating MTF location.

(10) Budget for and send assigned PM clerks to the TPMRC-E for initial (within 3 months of assignment to position) and periodic refresher PM training as required. Ensure MTF PM personnel are retainable in the duty position for at least one year. When advised by TPMRC-E,

coordinate and support TPMRC-E liaison visits.

(11) Transport patients to port of debarkation or to a supporting staging facility. If a staging facility is used, the staging facility is responsible for transporting patients from the staging facility to the port of debarkation. The MTF (or staging facility if used) will provide patient care before debarkation. When transportation to the MTF is required at en route stops or to final destination when a staging facility is not used, transport patients to the medical facility.

(12) Perform all preparations, briefings, and final clearance actions IAW service guidance appropriate to the mode of transportation. When aeromedical evacuation is used, provide medical briefing and patient documents to Medical Crew Director.

(13) Use TRAC2ES to record patient departure immediately or as soon as possible after departure. If TRAC2ES is not available, notify TPMRC-E via voice communication. Follow TPMRC-E guidance regarding specific in-transit visibility information to report. Minimum ITV events include: arrive/depart MTF, arrive/depart airfield, admitted/discharged MTF, and check-in/out billeting, as applicable to the patient. If a patient is traveling via commercial conveyance, the ITV entry should include the carrier, itinerary and any applicable coordinated ground transportation.

(14) Initiate PMRs for remote patients in their areas of responsibility per the TRICARE "Remote Site Areas of Responsibility" table (see TPMRC-E website for listing).

e. TRICARE Europe will:

(1) Advise TPMRC-E, in coordination with the TRICARE Management Agency when necessary, regarding TRICARE patient movement benefits. Facilitate TRICARE PM benefit delivery when required/authorized.

(2) Assist MTFs with the development and maintenance of host nation preferred provider networks to maximize opportunity for local care, thereby minimizing the requirement for patient movement.

f. TPMRC-E will:

(1) Maintain 24-hour operations to provide clinical validation, medical regulating, and coordination of PM requirements. Select and recommend the most appropriate and efficient means of transportation through the various levels of health care support for all patients to, from, and within the USEUCOM AOR/AOI. Monitor and provide patient movement ITV.

(2) Coordinate with supporting service component resource providers, the AMOCC AE Cell, other component transportation agencies, the USEUCOM JMC, the USTRANSCOM GPMRC, the AMC TACC, and commercial transportation agencies to identify assets for inter- and intra-theater PM. Coordinate and communicate PM requirements for execution.

(3) Recommend to the USEUCOM Commander programs, policies, procedures, and guidance for eligible beneficiaries and other potential users of the theater PM system.

(4) Advise the USEUCOM Commander on the theater PM system with input to deliberate and crisis action plans.

(a) Prepare and maintain TPMRC-E emergency expansion and contingency plans, including coordination and communication with forward-based medical regulating functions (see TPMRC-E website).

(b) Implement policies and procedures to meet the demands of contingency or urgent patient movement situations and assist lead commands in establishing patient movement concept of operations.

(5) Provide feedback and staff assistance to MTFs, medical evacuation/regulating agencies, and component surgeon staffs to support peacetime, exercise, and contingency PM. This includes biannual liaison visits to MTFs to provide information and operational guidance on reporting, preparation, and movement of patients.

(6) Provide operational reports of TPMRC-E activities upon request to the USEUCOM Surgeon's Office.

(7) Develop and maintain website including guidance, procedures, instructions, and samples as referenced in this directive. Maintain the webpage at https://sg.usafe.af.mil/tpmrc/.

(8) Manage theater regulation policies in coordination with USEUCOM Surgeon.

(9) Provide PMRC functionality to USCENTCOM unless a PMRC is established by USCENTCOM.

8. Contingency Operations.

a. Joint Force Surgeon will:

(1) Establish a joint patient movement concept of operations.

(2) Identify communications requirements necessary to integrate the functional aspects of joint patient movement.

(3) Integrate patient movement elements, including the tasks of forming a "one-stop" PMRC when necessary, delineating service and PMRC responsibilities and lines of authority, and establishing joint procedures.

b. If established, JPMRC element(s) will:

(1) In coordination with TPMRC-E, provide forward PM support to designated task force commander. This includes acting as the single responsible agent in the respective theater (or JTF) area of operation for integrated lift-bed planning, patient movement requirements definition and management, and patient in-transit visibility.

(2) Provide clinical validation, medical regulating, and coordination of task force PM requirements above Level II/III. Select and recommend the most appropriate and efficient means of transportation through the various levels of health care support for task force patients to, from, and within the USEUCOM AOR/AOI. Monitor and provide patient movement ITV.

(3) Coordinate with supporting service component resource providers, the USEUCOM TPMRC, the USTRANSCOM GPMRC, the AMC TACC, the AMOCC/AE Division, other service agencies and commercial transportation agencies as appropriate to identify assets for inter- and intra-theater PM. Coordinate and communicate PM requirements for execution.

(4) Recommend programs, policies, procedures, and guidance for eligible beneficiaries and other potential users of the theater PM system to the JTF Surgeon and Commander for approval.

(5) Advise on the theater PM system with input to crisis action plans and current operations.

c. MTF Responsibilities.

(1) Provide medical capability and bed status reports to the PMRC daily or as directed.

(2) Follow MTF responsibilities and patient reporting guidelines outlined in paragraphs 7.d. and 8. of this document and the TPMRC-E website.

d. Abbreviated Reporting Formats. TPMRC-E can approve the abbreviated reporting format using the TRAC2ES mass PMR, allowing automated reporting of essential information to streamline the PMR process. If TRAC2ES capability is unavailable, patient reporting may be accomplished using the abbreviated format provided at the TPMRC-E website.

e. Contingency Reporting. TPMRC-E can initiate contingency reporting when necessary. A voice template format or message format will be used for informational reports. The contingency mode formats are provided at the TPMRC-E website.

9. Policies.

a. Patients will be moved to nearest appropriate military MTF/source of care with the specified medical capability where appropriate treatment can be received, while supporting the optimum utilization of medical and transportation resources. MTFs must determine that less expensive, acceptable quality care is not available locally prior to requesting movement. Furthermore, a competent medical authority must confirm the need to move the patient prior to movement. Exception to policy requests must be approved by the TPMRC-E (see TPMRC website for sample).

b. Direct liaison and communication is authorized and encouraged among component commands, military MTFs, transportation/movement agencies within Europe, and TPMRC-E to expedite patient regulation and movement.

c. Except for U.S. Armed Forces patients and those otherwise determined appropriate, no person may be provided DoD-sponsored PM unless there is an emergency involving immediate threat to life, limb or sight, and suitable commercial care/transportation is not available, feasible or adequate. The TPMRC-E will coordinate requests for foreign national movement with USEUCOM Surgeon's Office and Joint Operations Center (JOC). Prior to validating movement TPMRC-E will ensure compliance with applicable references to this Directive and ensure the host nation approves entry for the foreign national.

d. The USEUCOM PM system will promote patient safety and assure the highest quality of care is provided in transit. IAW USAFE/CC procedures notifications will be made of any incident occurring during a patient's journey through the USEUCOM patient movement system which results in an interruption in movement or plan of care. TPMRC-E will provide immediate event management assistance, medical direction, and will facilitate information collection for action. Serious medical incidents will be reported to the USAFE Command Surgeon by the affected AE unit. As needed, USEUCOM and/or USTRANSCOM Surgeon may be included for risk management and/or quality assurance purposes.

e. No TPMRC-E validated patient shall be refused aeromedical evacuation within the USEUCOM AOR/AOI without consultation with the TPMRC-E Patient Movement Clinical Coordinator (PMCC).

f. Intratheater patients going for further evaluation or treatment, and generally all intertheater patients, must have an accepting physician at the destination MTF. The sending MTF is responsible for obtaining an accepting physician. If unable to confirm acceptance and/or assistance is required in obtaining a destination MTF and/or accepting physician, the sending MTF should contact TPMRC-E for guidance.

g. The primary mode of communications for all patient movement requests (PMRs) is TRAC2ES. Unless otherwise specified, all regulating messages will be unclassified.

h. MTFs will create a patient movement record in TRAC2ES for all intra- and intertheater patient movement requirements, regardless of the transportation mode or shift in patient accountability. When TRAC2ES is not available (e.g., far-forward deployed units, 6th Fleet afloat commands, etc.), TPMRC-E will create a patient movement record and PMR on behalf of the MTF. See TPMRC-E website for sample message/data collection formats.

i. Service components are responsible for providing funding for patient movement to include transportation costs and per diem based on service component regulations.

j. Transferring facilities are responsible for coordinating billeting arrangements and ground transportation, as required, at the destination location for all patients and non-medical attendants. Sending and receiving MTFs will provide transportation of patients to and from ports of embarkation/debarkation (POE/POD) or ASF, if established. The ASF, when established, will be responsible for transportation between the ASF and the respective airfield.

k. Unaccompanied minors (under the age of 18), or any unaccompanied non-active duty patient who is not capable of directing his/her own care, must have a DD Form 2239, Consent for

Medical Care and Transportation in the Aeromedical Evacuation System or a Power of Attorney (POA). The DD Form 2239 or POA will be filed in the patient's medical record, with a copy attached to the DD Form 602, Patient Evacuation Tag (or equivalent form) and will be annotated with the parent or guardian's address and telephone numbers.

l. Patients 14 years of age and under must have a medical or non-medical attendant. Only one able-bodied member of the immediate family may be authorized to accompany the patient as a non-medical attendant. Additional family members may be requested to accompany the patient as an exception to policy. If a member of the immediate family is not available, another adult may accompany the patient in a nonmedical attendant status on determination of need and written justification. TPMRC-E is approval authority for exceptions to this policy. See TPMRC-E web site for sample request.

m. Apparent en-route deaths on USAF aircraft will be managed IAW procedures identified in AFTTP 3-42.5. Component surgeons should ensure appropriate service procedures are followed to manage the human remains properly and engage the mortuary affairs community for action.

FOR THE COMMANDER:

JOHN B. SYLVESTER
Lieutenant General, U.S. Army
Chief of Staff

OFFICIAL:

WILLIAM L. KISER
Chief, Support Services

APPENDICES:

A. TPMRC-E/CONTINGENCY STAFFING
B. COMMERCIAL TRAVEL MATRIX

DISTRIBUTION:
P

Appendix A

TPMRC-E STAFFING

1. <u>Peacetime Staffing</u>. TPMRC-E manpower to support 24-hour operations currently consists of 20 personnel. On-call flight surgeon support is available 24 hours per day to provide consultation for validation of urgent and priority patients as well as patient management issues. Peacetime TPMRC-E staffing is as follows:

TPMRC-E IN PLACE STAFFING					
TITLE	**GRADE**	**SKILL**	**CL**	**QTY**	**SVC**
Commander	O-5	41A4	S	1	F
Deputy Commander, Clinical Support	O-4	46A4	S	1	F
Deputy Commander, Administration	O-4	41A4	S	1	F
PM Operations Officer (PMOO)	O-3	41A4	S	3	F
PM Clinical Coordinator	O-3	46F4	S	4	F
Superintendent/First Sergeant	E-7	4A071	S	1	F
PM Information Systems	E-6	4A071	S	1	F
PM Operations	E-6	4A071	S	1	F
PM Coordinator	E-6	8404	S	1	N
PM Coordinator	E-6	91G30	S	1	A
PM Coordinator	E-5	4A051	S	4	F
Command Support Staff	E-5	71L20	S	1	A
Total				20	

2. <u>Contingency Augmentation Staffing</u>. Augmentation levels may vary from 3 to 18 personnel, depending on scope of operations supported. Augmentation requirements are based on TPMRC-E in-place duty positions and do not include backfill associated with deployment of TPMRC-E staff members. All service component commanders shall ensure that personnel meet the mandatory requirements identified in the following positions:

TPMRC-E AUGMENTATION					
TITLE	**GRADE**	**SKILL**	**CL**	**QTY**	**SVC**
Medical Operations Manager	O-4	70E	S	1	A
Medical Operations Manager	O-4	2300-1805	S	1	N
PM Operations Officer	O-3	70E	S	2	A
PM Operations Officer	O-3	2300	S	1	N
PM Clinical Coordinator	O-3	46N3 or 46F3	S	3	F
PM Operations	E-6	4A071	S	1	F
PM Coordinator	E-6	91G30	S	1	A
PM Coordinator	E-6	8404	S	1	N
PM Coordinator	E-5	4A051	S	2	F
PM Coordinator	E-5	91G20	S	2	A
PM Coordinator	E-5	8404	S	1	N
PM Information Systems	E-5	4A071	S	2	F
Total				**18**	

3. <u>JPMRC Staffing</u>. JPMRC staffing provides for 24-hour operations at TPMRC-E or as part of a joint task force. Validating flight surgeon support is through the TPMRC-E when required; or a validating flight surgeon can be deployed as part of the JPMRC. Substitutions are authorized IAW service policies.

JPMRC STAFFING – UTC FJPMC					
TITLE	**GRADE**	**SKILL**	**CL**	**QTY**	**SVC**
Director	O-5	041A4/ 70E67/ 2300-1805	S	1	Any Service
Medical Operations Manager	O-5	041A4/ 70E67/ 2300-1805	S	1	Any Service
PM Clinical Coordinator	O-4	X046F3	S	2	F
PM Operations Officer	O-3	70E67	S	1	A
PM Operations Officer	O-3	2300-1805	S	1	N
PM Coordinator	E-7	8404	S	1	N
PM Coordinator	E-7	91C40	S	1	A
PM Coordinator	E-7	4N071	S	1	F
PM Operations	E-7	4A071	S	1	F
PM Coordinator	E-6	8404	S	1	N
Comm-Systems Information	E-7	74B40	S	1	A
Total				**12**	

Appendix B

PATIENT MOVEMENT PROCESS